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ABSTRACT

This guide covers program components and models for the provision of health and health related services to refugees. The document identifies the necessary components in a health services continuum and outlines a range of health care approaches for refugees that are reflective of successful programs in the United States. This pamphlet is intended to aid in the selection of health services that will suit each community. In addition, it serves as a guide for evaluating current health care efforts, strengthening existing programs and developing new proposals.

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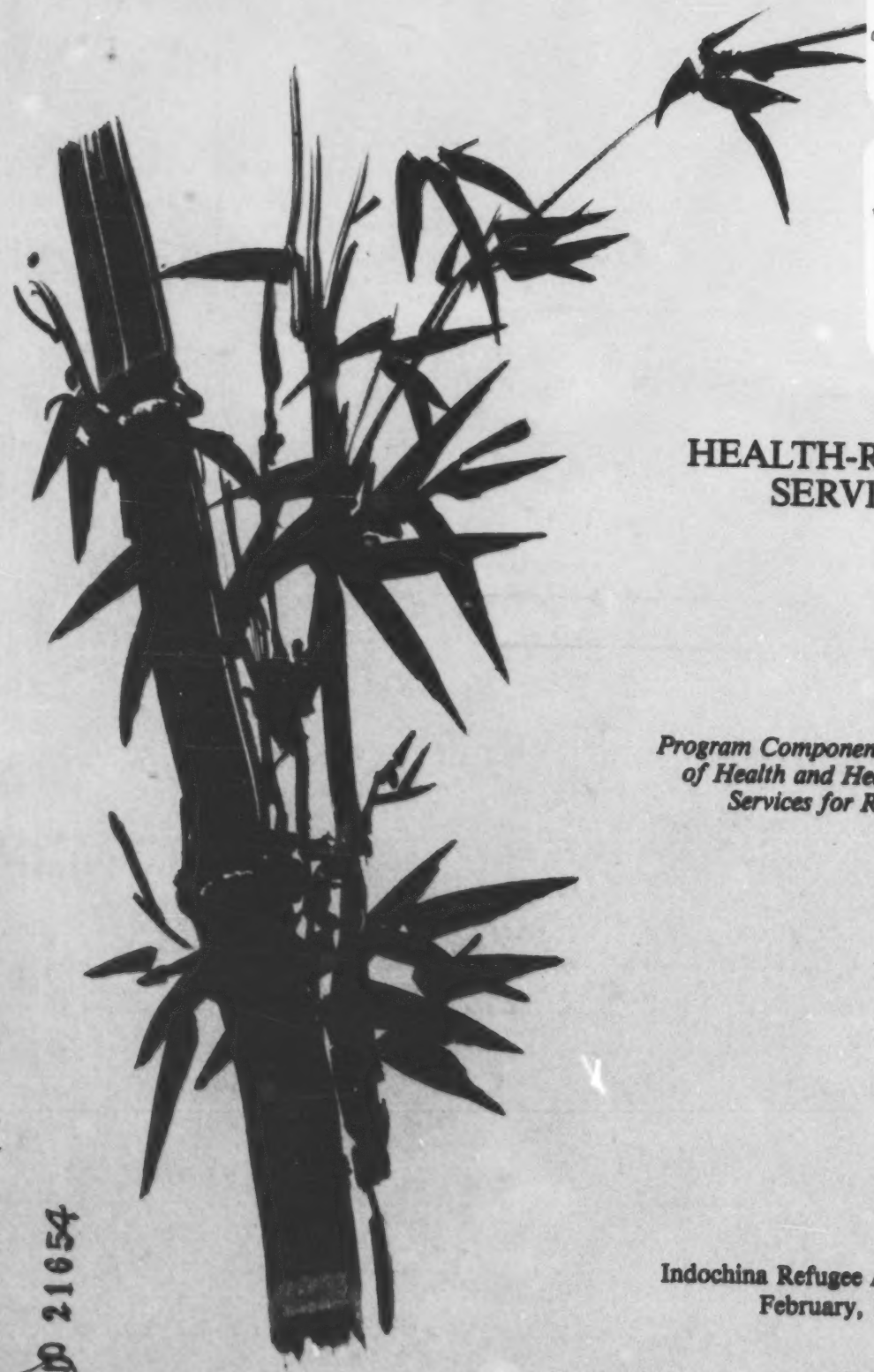

HEALTH-RELATED SERVICES

Program Components and Models of Health and Health-Related Services for Refugees

UD 21054

Indochina Refugee Action Center
February, 1981

DOCUMENT SERIES

Program Components and Models of
Resettlement Services for Refugees

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HEALTH-RELATED SERVICES

Program Components and Models
of Health and Health-Related Services
for Refugees

Developed in the
Practitioner Workshop
on Health-Related Services
Somerville, Massachusetts
September 11-13, 1980

Sandra DuVander, Lead Consultant
and Principal Author

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Roger Harmon, Ph.D., Project Director
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DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

February 25, 1981

Dear Colleagues in Refugee Resettlement:

Enclosed you will find a document on program components and models for the provision of health and health-related services to refugees. The document identifies the components in a health services continuum, and delineates a range of health care approaches for refugees. These approaches are reflective of successful health care programs currently administered in the United States for refugees.

The document is meant to be of use in identifying the arrangement of health services that will best fit your community. In addition, it will serve as a guide for evaluating current health care efforts, strengthening existing programs and/or developing new proposals.

This document is the second of seven work products being produced in the Practitioner Workshop Project conducted by the Indochinese Refugee Action Center (IRAC). These documents are the work of local service providers who have innovative ways of meeting the needs of refugees. The Office of Refugee Resettlement wishes to thank the participants of the Health-Related Services workshop for donating their time and energy. They have made possible a document which will be of assistance to others throughout this country who are working in refugee resettlement.

Sincerely,

Roger P. Winter
Director
Office of Refugee Resettlement

Indochina Refugee Action Center

1025 Fifteenth Street NW, Suite 600
Washington, D.C. 20005
(202) 347-8903

March 1, 1981

Dear Friends:

In September, 1980, sixteen individuals with expertise in providing health-related services to refugees met in Somerville, Massachusetts, a suburb of Boston. The task of the workshop participants was to set forth necessary program components and effective models for providing health care to refugees. In two and one-half days of meetings they began a process which has resulted in the document before you.

In the meetings, conducted by Sandra DuVander, lead consultant, the participants described their experiences and the programs they represent. Using the format and material developed in the meetings, the lead consultant wrote a draft of the document and circulated it to the participants for revision. A second draft was then sent to the Practitioner Workshop Project staff for final editing, prior to submitting the document to the Office of Refugee Resettlement.

We owe a debt of gratitude to Sandra DuVander and the other participants who have worked so hard on this document. They are extremely busy people who have donated a good deal of time and energy to this project. They have looked beyond their own individual interests and specialties to describe in a systematic way, the health care continuum which includes identification and intake, health assessment and ongoing health care.

The Office of Refugee Resettlement has given excellent support to this endeavor; we especially want to thank Kay Rogers (Chief) and Kathy Do (Project Officer) of the Program Development unit for their contribution. Dr. Laurence Farer, a workshop participant, and Kathy Rufo and G. Russell Havlak of the Center for Disease Control, U. S. Public Health Service, have also given encouragement and many helpful suggestions.

We hope this document is of use to you. We welcome your comments on it, and have included a short questionnaire, should you wish to respond.

Sincerely,

Roger E. Harmon

Roger Harmon, Ph.D.
Project Director
Practitioner Workshop Project

Preface

The provision of health care to refugees is often viewed as being distant or even separate from the services commonly associated with resettlement. Nonetheless, the ability of refugees to successfully hold a job, study English, and pursue skills training is highly dependent on their state of health. Meeting the goal of refugee self-sufficiency and well-being presents a challenge to communities to provide effective and appropriate health care. This calls for the partnership of health care providers and other resettlement service providers to coordinate the planning and delivery of necessary services for refugees.

The purpose of this document is to identify the service components necessary in a health care program for Indochinese (and other) refugees, and to discuss various approaches and delivery considerations for providing these health services. It is hoped that the document will prove useful both to health care providers seeking to enhance program capacity and effectiveness, as well as to state and local program administrators faced with planning and funding decisions.

A legislative and contractual framework is now in place that will promote more effective health care for refugees. The Refugee Act of 1980 (Public Law 96-212) contains provisions for the identification and monitoring of refugees who arrive in this country with significant health problems. It also includes provisions for 100 percent federally-reimbursed medical assistance to income-eligible refugees for the first three years after their arrival.

Current program instructions from the Department of Health and Human Services, Office of Refugee Resettlement, dated August 24, 1979 (SSA-AT-79-33) outline a range of health-related services that are allowable under Refugee Resettlement Program social service funding. These health-related services include the following:

> "...Information, referral to appropriate resources; assistance in scheduling appointments and obtaining services; and counseling to individuals or families to help them understand and identify their health needs and maintain or improve their health."

Other allowable Refugee Resettlement Program services that might be incorporated into a refugee health program include outreach services, translation and interpreter services (including staff training to improve the ability of bilingual staff to deliver services), and nutrition counseling as a home-management service.

The latest reception and placement contracts between the Department of State and voluntary and state resettlement agencies specify that resettlement agencies have the following responsibilities in helping refugees gain access to an adequate source of health care.

(1) Encourage and assist the refugees as soon as possible after arrival to seek health services available through the local health system (public or private) and assist refugees with known health problems to secure follow-up treatment as necessary.

(2) Coordinate with the local health authorities on programs which assist in health care, orientation and education of the refugee about the health care system.

In addition, the U. S. Public Health Service (PHS) has statutory responsibilities relating to the screening, immunization, and processing of refugees migrating to the United States. The Center for Disease Control (CDC) is primarily responsible for these activities, and also administers a grant program to help states and communities address refugee health problems and provide general medical screening (see Appendix D).

Finally, refugees are eligible for a variety of health and health-related services that are available - assuming necessary criteria are met - to the general populace.

This document addresses the spectrum, or continuum, of refugee health services and identifies a variety of funding resources being used by communities throughout the country. The document supports the perspective that states or communities can best plan and deliver refugee health services when, first of all, they understand the full spectrum of health services that should be considered and, secondly, can identify the necessary resources to provide any given part of those services.

This document is the result of an intensive, three-day health workshop held in Somerville, Massachusetts (a Boston suburb) on September 11-13, 1980. The second in a series of seven practitioner workshops on various resettlement service topics, the Health-Related Services Workshop included 16 participants involved in refugee health services around the country. These participants represented state and local health departments, voluntary agencies, state refugee offices, community health centers, university programs, private practices, and federal hospitals and health agencies. Several bicultural health personnel also participated. The participants' principal experience has been with Indochinese refugees but the basic service components described in the document should apply to programs for other refugee populations as well.

While this document outlines rationales, guidelines, and program suggestions to help communities make better, more informed decisions in developing health care services for refugees, it does not represent all the approaches or models for delivering health care. The document is a starting point. It is hoped it will help communities meet their responsibilities of improving and maintaining the health status of refugees so they may more quickly become self-sufficient and well-adjusted members of our neighborhoods, towns, and cities.

TABLE OF CONTENTS

Page

I. INTRODUCTION

A. General Background 1

B. Document Format - Service Components 3

CHART I: Refugee Health Services Continuum. 5

II. IDENTIFICATION AND INTAKE

A. Background 7

B. Service Activities 8

1. Identification and Intake of Specific Target Groups 8

a. Newcoming Refugees with Class A or B Tuberculosis. 8
b. Newcoming Refugees without Class A or B Tuberculosis. 9
c. Secondary Migrant Refugees 11

2. Outreach to the Refugee Community. 11

3. Orientation of Refugees and Sponsors 12

C. Delivery Considerations 13

1. Location of Health Services. 13

2. Transportation 13

3. Financial Access to Health Services. 14

CHART II: Suggested Roles and Responsibilities in the Identification and Intake Process. . . .16

III. HEALTH ASSESSMENT OF REFUGEES

A. Background 17

B. Service Activities 19

1. Brief History. 19

2. Physical Examination 20

3. Laboratory Procedures. 21

4. Needs Assessment for Referral to Supportive Health Services 22

Table of Contents - Cont'd.

Page

C. Delivery Considerations 24

1. State Planning Structure. 24

2. Local Planning Structure. 25

3. Direct Service Providers. 25

CHART III: Service Provider Options for Health Assessment 27

IV. ONGOING CARE OF REFUGEES

A. Background 28

B. Service Activities 29

1. Essential Services 29

2. Important Services 29

3. Desirable Services 30

C. Delivery Considerations. 30

1. Coordinated Community Services 30

2. Specialized Services for Refugees. 31

3. Personnel. 31

4. Interpreter/Translation Services 32

CHART IV: Components of Ongoing Care. 33

V. IMPORTANT SUPPORTIVE SERVICES

A. Bilingual/Bicultural Personnel 34

B. Financial Mechanisms 35

APPENDICES:

A -- Practitioner Workshop Project. 38

B -- List of Participants 41

C-1 -- Program Descriptions 44

C-2 -- Resource Outline 50

D -- Center for Disease Control: Program Description. 53

E -- Refugee Act of 1980: Health Service References. 56

I. INTRODUCTION

A. Background

Refugees come to this country with a variety of problems produced in part by harrowing escape experiences and long-term encampment. Illness and disease often accompany such experiences. The Morbidity and Mortality Weekly Report (MMWR), published by the Center for Disease Control, contains data that document the high prevalence of problems that need to be addressed. 30-60% of the Indochinese refugees have positive tuberculin tests; 60-70% have one or more parasites; 12-21% are hepatitis B antigen positive; 3-16% have positive VDRL's; 20-40% have anemias and malnutrition; 70-95% need immediate dental care; 10-15% have skin problems; and significant numbers of refugees have been seen with otitis media, eye problems, hearing loss and malaria. While these problems for the most part only pose personal health threats to the refugees, some conditions (tuberculosis, for example) may pose potential public health threats if left untreated.

The provision of appropriate and effective health care services to refugees is complicated by a myriad of cultural and linguistic barriers reflecting the many fundamental differences between traditional Indochinese health care concepts and practices and those to which they are introduced in the United States. These barriers include the following:

- Health practitioners and refugees are frequently unable to communicate about common health conditions and the appropriate methods of treatment.
- Treatment regimens prescribed by physicians are frequently not carried out (e.g. medications are not taken correctly, or not taken at all.)

- Refugees often seek medical help only after their condition has become quite serious, thereby complicating treatment.
- Refugees often distrust health services owing to a lack of understanding of medical terminology and practices, a resistance to physical exams and laboratory tests, and a fear of being deported if a serious health problem is identified.
- Refugees are frequently unfamiliar with American foods and procedures for preparation and storage; there is often a lack of understanding about the relationship between nutrition and diet-related disease.
- Limited income often prevents refugees from obtaining a basic, adequate and balanced diet.
- Refugees often lack knowledge of personal health and safety practices (e.g. dressing warmly enough in winter, use of electrical appliances, etc.).
- Somatic symptoms (headaches, stomach aches, chills, etc.) are sometimes indicative of underlying emotional traumas and adjustment problems.
- Sponsor attitudes toward health care often affect consideration of appropriate health measures.

Some of these specific areas of sensitivity are further explored below along with discussion of appropriate responses; however, this document does not attempt to be a detailed guide on overcoming cultural barriers to health care.

To properly address the specific health needs of refugees, well-planned and coordinated services are required, but these services need not be either elaborate or expensive. The following factors have been identified as being crucial to the provision of effective health care to refugees:

- planning and coordination at the state level;
- establishment of a continuum of health services that are culturally, geographically and financially accessible; and
- development of linkages with other resettlement services, and with supportive physical and mental health services.

The establishment of a continuum of services is an objective shared by all health care programs whether or not they serve refugee populations. As outlined in this document, the health services continuum includes the three basic components of 1) identification and intake, 2) health assessment, and 3) ongoing care (see Chart I, page 5).

While each component has its own service structure and responsibilities, it is very important that all three be given due consideration by a community in planning and developing its refugee health services. Isolating and investing heavily in one component may be far more detrimental to meeting refugee health needs than developing a more simplified structure that addresses all three components minimally. Each component is interlinked with the next. A state or community should examine the many facets of the health services continuum to determine the most effective arrangement of services for that area. Some of the local factors that should be considered in determining effective approaches are as follows:

1. the location and arrangement of existing health services;
2. the size of the refugee population and its geographical distribution; and
3. the availability of other resettlement resources in the community to whom referrals can be made and from whom support can be drawn (e.g., social adjustment services, voluntary agencies, MAA's, etc.)

B. Document Format

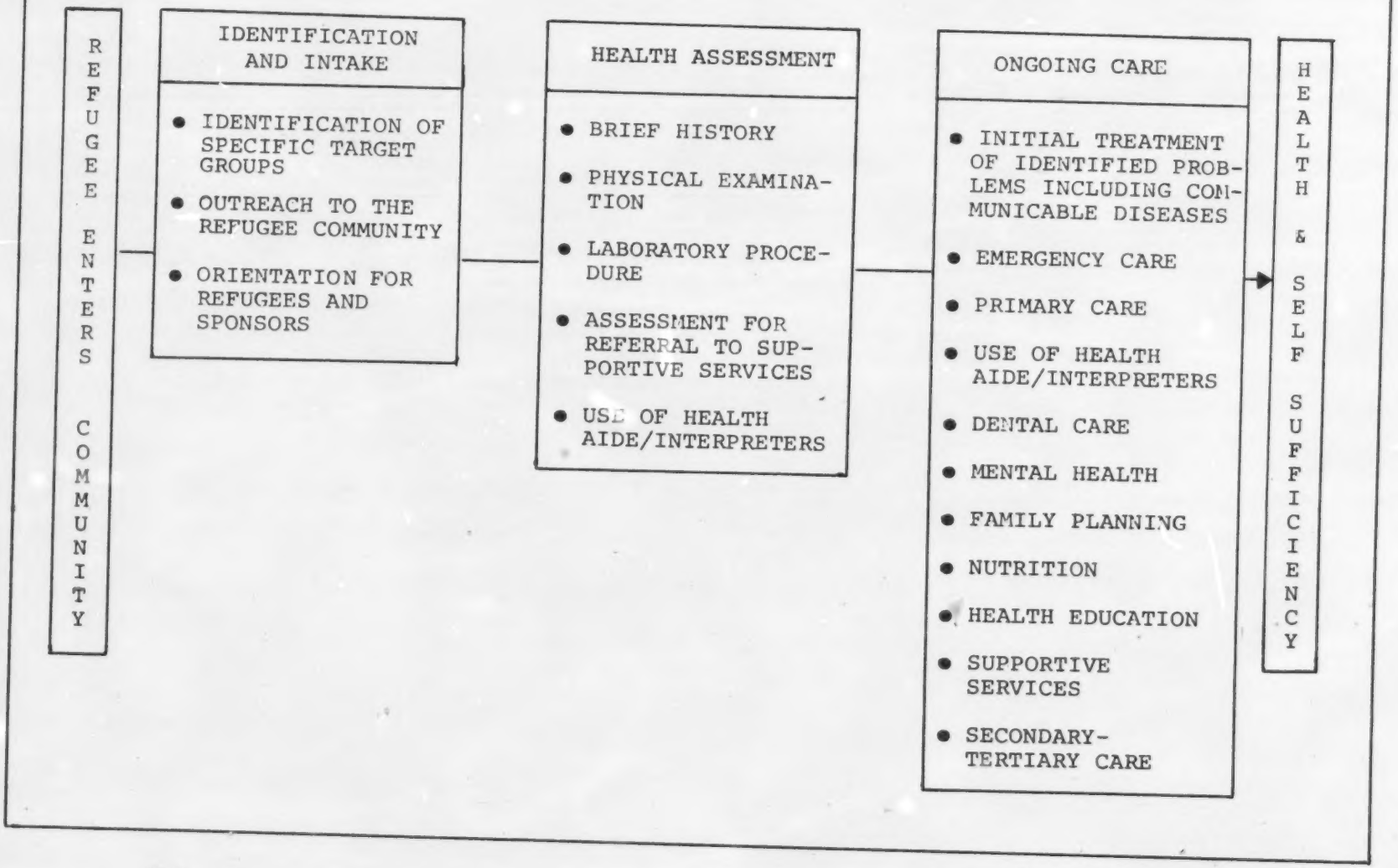
This document has been organized in terms of the three basic components of identification and intake, health assessment, and ongoing care. In addressing each of these essential components, discussion is given on (a) service activities and

(b) delivery considerations. A fourth section of the document gives expanded consideration to two critical supportive components (the use of bilingual/bicultural personnel and available financial mechanisms); these considerations have a particularly strong impact on any community's ability to deliver services to refugees.

The Appendices contain names, addresses and telephone numbers of the participants; brief descriptions of programs represented by the participants; and an outline which matches the topical categories of the document with specific areas of expertise of the programs represented at the workshop.

In sharing their experiences, the workshop participants articulated their belief that the meeting of health care needs of refugees can be approached in a systematic way. The models addressed in this document represent the various approaches developed by some of the established health programs for refugees throughout the United States. They reflect the range of resources available in different geographic areas and the diversity of innovative solutions to sometimes unusual situations.

CHART I: REFUGEE HEALTH SERVICES CONTINUUM



II. IDENTIFICATION AND INTAKE

The first component of the health service continuum is identification and intake. In order for a state or community to plan and develop refugee health services, they must be able to determine how many refugees they are going to have to serve, where the refugees are located, and how they can best be served. In terms of identification and intake procedures, many communities must deal with two very different types of refugee populations:

1. Newcoming refugees, who arrive in this country from overseas with documentation of overseas medical screening and immunization activities, and advance notification of their arrival, and

2. Secondary migrants, that is, refugees moving into a community from other parts of the state or country - who generally arrive without notice and with little or no record of health care that may have been provided elsewhere.

The first part of this section relates to newcoming refugees and briefly describes the procedures for overseas screening and immunization, and the process of advance notice and documentation by means of which state and local health departments are informed of the refugees' arrival and their specific medical needs. Document routing and notification procedures vary for newcoming refugees, depending on whether or not these refugees have Class A or B medical conditions (see discussion below).

The routing and notification procedures for newcoming refugees, as well as suggestions for the identification of secondary migrants in a community, are described below in the discussion on "Identification and Intake of Specific Target Groups." Following this description, this section considers:

- outreach to the refugee community,
- health orientation, and
- geographical and financial access to health care.

A. Background

1. Overseas Screening

Prior to final clearance for resettlement in the United States, refugees in Southeast Asian camps must undergo a medical screening for tuberculosis, venereal disease, leprosy, and mental disorders. Immunizations are also initiated in these overseas camps for the seven childhood diseases -- diphtheria, pertussis, tetanus, polio, measles, mumps, and rubella.

2. Advance Notice and Documentation

Refugees coming from the Southeast Asian camps arrive in this country with advance notice and documentation. The following four documents contain biographical and medical information that is of primary importance to state and local health departments and other health providers.

a. American Council of Voluntary Agencies (ACVA) Form #1. This form contains the refugee's name, INS alien registration number, age, sex, date and place of birth, number in family, and sponsor's address. If the refugee has either Class A (active, non-infectious) tuberculosis or Class B (inactive) tuberculosis, that is also indicated on the form.

b. OF-157 Medical Examination of Visa Applicants. This form documents the results of the overseas screening procedures, and indicates those health conditions that warrant prompt attention, particularly Class A (active) and Class B (inactive) tuberculosis.

c. Chest X-ray for tuberculosis.

d. Immunization record. This form documents the immunization schedules that were initiated in the overseas camps.

It is likely that local health providers may receive several copies of the same form (ACVA-1, OF-157, Immunization Records, etc.), depending upon whether they arrive from U.S. Quarantine Stations, state health departments or resettlement offices, or voluntary agencies. The establishment of an identification and intake structure focusing on the specific target groups discussed below will greatly facilitate the information flow and the delivery of services to refugees.

B. Service Activities

1. Identification and Intake of Specific Target Groups

The screening and documentation described above are carried out for all Indochinese refugees entering the United States, regardless of their medical status. There are, however, variations in the routing procedures for Optional Form-157 (OF-157) and other variations in the identification and intake process, that apply to the following specific refugee groups:

a. Newcoming Refugees with Class A or B Tuberculosis

For refugees arriving with Class A or B tuberculosis (TB),* the following identification and intake procedures should be carried out:

(1) The state health department should inform the Quarantine Division, CDC of the specific local health departments that should be receiving information about the health status of arriving refugees to ensure prompt receipt of the OF-157 form. The Quarantine Division will, in turn, be able to provide the port-of-entry Quarantine Stations with updated information on the local health departments.

* Other Class A or B medical conditions include venereal disease, mental disorders, and - extremely rarely - leprosy. Tuberculosis is by far the most common Class A or B medical condition and is, therefore, highlighted in this document.

(2) The Quarantine Officer at a U.S. port-of-entry mails copies of the OF-157 and ACVA-1 forms of the arriving refugee to the:

- state health department,
- local health department, and
- Quarantine Division, CDC.

(3) In cases of Class A conditions only, the Quarantine Officer notifies the local health department by phone so that necessary preparations can be made.

(4) The state and local (city or county) health departments should review the ACVA-1 and OF-157 forms to identify refugees with Class A or B conditions.

(5) The state and local health departments should establish appropriate routing procedures for the ACVA-1 and OF-157 forms so that local health care providers get this information promptly.

(6) Refugees with Class A or B status have been instructed to present their own copies of the ACVA-1 and OF-157 forms, along with their chest x-ray film, to the local health department and/or other health care providers.

(7) The local health department should initiate outreach procedures if refugees do not come in within a short time of their arrival in the community.

b. Newcoming Refugees without Class A or B Tuberculosis

(1) Refugees arriving at a U.S. port-of-entry without Class A or B conditions are instructed by the Quarantine Officer to present their chest x-ray film and one copy of the OF-157 to their local health department (or other health care provider). They should keep a copy of the OF-157 for their personal use.

(2) The Quarantine Officer mails only the ACVA-1 form to the state and local health departments. The copy that goes to the local health department has the refugee's Immunization Record attached.

Special Considerations:

The ACVA-1 form provides state and local health programs with the ability to monitor refugee flows into their area and do more adequate planning for services. The following procedures are recommended regarding this form:

- The state health department or the state refugee office should organize the ACVA-1 form chronologically, by date of the refugee's entry to the U.S. This information should be useful for epidemiological analysis and computing of monthly arrival figures.

- Either of the above state offices or the local health department should prepare a listing of refugees for follow-up, billing, etc. Such a listing should enhance the capability of tracking refugees and planning services. The information listed can include name, identification (alien registration) number, sex, date and place of birth, date of entry into the U.S. and voluntary agency sponsor.

  Note: Since this information is both personal and confidential, distribution should be limited. (Rules and regulations relating to the Refugee Act of 1980, stipulate that distribution should be only for purposes directly relating to the administration of the program.)

- Registration staff should be instructed:

  (1) on the importance of confidentiality, and
  (2) on the proper order of Indochinese names so that record keeping will be consistent.

- The state or local health department, or the state refugee office, should prepare periodic data summaries for distribution to appropriate program administrators and service providers. The data summary might include age, sex, family size, voluntary agency sponsorship, and country of birth (or ethnic group if known). Such data summaries should be useful for planning purposes.

c. Secondary Migrant Refugees

Refugees moving from their initial resettlement location to another part of the state or country, arrive in a community generally without notice and with no record of health care that may have been provided in other communities.

The state or local health department and/or the state refugee office should do what is possible to track secondary migration into and within their jurisdiction. To reduce the possible duplication of health assessment services provided elsewhere, a local health department might consider developing a portable health card which identifies where, what, and when tests were performed. Refugees can then take such a card with them if they move or as they visit various health providers within the community.

Since secondary migrants are difficult to identify, assistance should be sought from a wide variety of service providers and community organizations including refugee self-help groups or mutual assistance associations (MAA's), voluntary agencies, ESL and vocational training programs, Office of Family Assistance, AFDC, Medical Assistance, SSI, Food Stamps, WIC, Job Corps, WIN, Handicapped Children's Bureau, educational institutions, and refugee businesses.

2. Outreach to the Refugee Community

State and local health programs should develop procedures by which they can effectively publicize available health services and encourage participation:

- Information networks should be established with voluntary agencies, sponsors, mutual assistance associations (MAA's), related health agencies and welfare offices.
- Health programs should disseminate information through the media, community agencies, refugee businesses, and professional organizations.
- Information and publicity materials should be developed in the languages appropriate to the local refugee population. Content should include the services offered, location, schedules and transportation information.

- Refugee health advocates should be used to publicize programs and direct refugees to appropriate health services.
- Local refugee health forums can be an effective channel for information.

3. Health Orientation for Refugees and Sponsors

It is critical that health issues be included as a topic in general orientation for refugees and sponsors to reinforce the notion that health care is an integral part of the resettlement process. Both refugees and sponsors need to be provided with a greater awareness of the following health-related topics:

a. Health conditions common among Indochinese refugees.

b. Appropriate use of health facilities. This should include:

(1) Information on available health services in the community.

(2) Information to be able to better assess what constitutes a medical emergency, and when to make use of the various types of health facilities.

(3) For refugees, cross-cultural orientation should be provided to American health concepts and practices. Topics should include making and keeping appointments, taking medication, health screening procedures (physical exam, lab tests, etc.).

c. Benefits of health care participation.

The benefits of the refugee's prompt participation in a local health care program should be made known to both refugees and sponsors. These benefits include:

(1) Prompt attention and appropriate treatment for existing health problems (ranging from treatment of communicable diseases to prescriptions for eyeglasses).

(2) Assurance of sensitivity to Indochinese cultures and customs (this would include availability of interpreters, as well as appropriate testing and referral).

(3) Continuation or initiation of immunization schedules to ensure prompt admittance of children to schools.

C. Delivery Considerations: Access to Health Services

1. Location of Health Services

In planning refugee health services, a community needs to carefully consider the location of these services, particularly the health assessment services. Different approaches would include:

(a) Centralized services which offer the advantages of pooling of resources; central monitoring, control and follow-up opportunities; and minimal confusion for the refugees in identifying appropriate health facilities. This approach may be particularly adaptable for highly impacted urban areas and regional programs serving adjacent counties.

(b) Decentralized services which minimize transportation needs and facilitate the geographical distribution of health services to meet specialized needs. This approach may work well for small, rural communities and large identifiable ethnic populations located by neighborhood in metropolitan areas.

2. Transportation

Transportation is always a problem in health outreach, but needs special consideration for refugees because of language barriers and lack of information regarding American public transportation systems.

Every effort should be made to assist the refugees in learning to use existing public transit systems. It is suggested that maps in the various refugee languages be made available.

Where public transportation systems are inadequate, the following resources should be explored:

- Voluntary agencies
- Sponsors
- MAA's and/or other refugees
- Health clinic transportation
- Contracted outreach services

The choice of options should be determined by the refugee's knowledge of English and level of self-confidence as well as by the availability of public transportation and the location of the health facility.

3. Financial Access to Health Services.

Financial access to health care has important ramifications for refugees as they are frequently encouraged by their voluntary agency and/or sponsor to take low-level employment as an initial step toward self-sufficiency. This employment usually does not provide health insurance, and the income level is just high enough to prevent refugees from qualifying for other forms of medical assistance.

State and local health providers need to consider all available health service options for their jurisdiction [e.g., WIC (Women, Infants, and Children), EPSDT (Early Periodic Screening, Diagnosis and Treatment), community clinics, etc.] and should identify the specific eligibility criteria refugees must meet in order to gain access to these services.

It is recommended that refugees be enrolled if eligible in some type of medical assistance program. Voluntary agencies and sponsors are frequently resistant to the idea

of refugees going on welfare -- generally a prerequisite to receive medical assistance. This enrollment should be seen as a short-term "insurance policy" to protect sponsors from large medical bills for the refugee, and to provide necessary health care to the refugees.

Voluntary agencies, sponsors, refugees, health care providers, and welfare staffs need to be informed about retroactive coverage for medical assistance reimbursements. This should help to prevent refugees from being without medical care while they are applying for medical assistance.

4. Summary.

Suggested roles and responsibilities of the state health department, local health department, the state refugee office, local voluntary agencies and community health programs in the identification and intake process are included in Chart II.

CHART II: SUGGESTED ROLES AND RESPONSIBILITIES IN THE IDENTIFICATION AND INTAKE PROCESS

AGENCY/ ORGANIZATION	IDENTIFICATION AND INTAKE OF SPECIAL TARGET GROUPS			OUTREACH	ORIENTATION
	REFUGEES WITH CLASS A or B CONDITIONS	REFUGEES WITHOUT CLASS A or B CONDITIONS	SECONDARY MIGRANT REFUGEES		
STATE HEALTH DEPARTMENT	inform CDC of appropriate local health jurisdictions, check ACVA forms, establish routing procedures for follow-up	organize ACVA forms, prepare refugee lists (for use in program operations), prepare periodic data summaries for planning purposes and distribution	participate in identification efforts	establish a clearinghouse for information regarding the availability of medical services	provide information to orientation services and health providers
LOCAL HEALTH DEPARTMENT	establish routing procedures for follow-up on Class A and B conditions	prepare refugee lists, and data summaries	participate in identification efforts, provide information to state offices	publicize sources of health care, publish and distribute information, coordinate or provide transportation, identify refugee advocates	conduct health orientations
STATE REFUGEE OFFICE		organize ACVA forms, prepare refugee lists and data summaries	coordinate identification efforts, disseminate information	coordinate and/ or monitor outreach efforts	coordinate information flow to orientation providers
LOCAL VOLUNTARY AGENCIES/ SPONSORS	assist in directing refugees to local health department	assist in directing refugees to local health department or other health providers who offer health assessment services	participate in identification efforts, provide information to state offices	provide or coordinate transportation, assist in identifying refugee advocates	conduct orientation to health services, stressing benefits of participation
COMMUNITY HEALTH PROGRAMS			participate in ensuring access to appropriate health care, provide information to state offices	coordinate transportation, publicize sources of health care	publicize information and sources of health care, could provide orientation
OTHER RESETTLEMENT PROGRAMS/ ORGANIZATIONS (including MAA's, mental health services, etc.)		assist in ensuring access to health assessment and ongoing care	assist in ensuring access to appropriate health care	MAA's could provide outreach services and serve as refugee advocates	MAA's and mental health services could provide health-related orientation

III. THE HEALTH ASSESSMENT OF REFUGEES

A. Background

The basic purpose of the initial health assessment or health screening is to evaluate and improve the health status of the refugees. Screening for communicable diseases that could constitute a public health hazard is carried out overseas before the refugees depart for the U. S. Health assessment programs developed in the U. S. provide follow-up on the conditions identified overseas, and offer an opportunity to detect other public and personal health problems in the refugees.

It is strongly recommended that all refugees should have access to an initial health assessment. The importance of screening has particular significance for the Indochinese refugee populations. With the general American populace, screening is usually carried out to identify asymptomatic problems. With the refugee populations, screening generally picks up symptomatic diseases. Indochinese refugees are not accustomed to sharing information about health problems, particularly when they do not consider them of great importance. As a consequence, refugees frequently do not present themselves for treatment until their problems are quite serious.

Additional suggested guidelines on initial health assessments for refugees are as follows:

- Interpretive services are an absolute necessity in most cases and can be provided in a variety of ways available to most communities. Health assessment and treatment provided without interpretation/translation to clarify what are undoubtedly

confusing and perhaps frightening procedures for refugees, runs the risk of negating the positive effects of the exam and creating barriers to any subsequent usage of services by the refugees.

- Health assessment services should be culturally acceptable to the refugees or they will not be used. Health providers need to be aware of the most significant differences between Indochinese and American health care concepts and practices. Some of these differences are identified in the narrative below. It should be emphasized again, experience has clearly identified the harm done in subjecting refugees to unfamiliar and perhaps frightening physical examination procedures without paying appropriate attention to the cultural expectations that might resist such procedures.

- Health assessment services should always be provided in conjunction with treatment and follow-up. Screening without treatment and follow-up can generate distrust and disruption of the refugee - provider relationship, and wastes the resources put into the screening effort in the first place. Communities need to assess their capabilities to treat problems that are identified.

Discussion in the sections below focuses on service guidelines and rationales that can assist communities in their choice of what to provide in health screening programs for refugees. An initial health assessment for refugees should include:

1. A brief history
2. A physical examination
3. Certain laboratory procedures, and
4. A special needs assessment for referral to supportive health services.

B. Service Activities

1. Brief History

The practice of using an expanded patient history to assess health problems is not appropriate with the refugee client. It is extremely difficult to obtain useful and appropriate information for the following reasons:

- Language barriers may prevent the refugee and health provider from accurately identifying past or present medical problems.
- Refugees, especially in their medical interviews with American providers, tend to deny or minimize previous illnesses and current symptoms. This may be due to cultural reticence in discussing personal problems, or fear that they may be deported for a severe illness.

Subsequent visits may yield more accurate information about a patient's medical history, once a feeling of trust has been established. Interviewers may need to word their questions in different ways to derive accurate information.

The brief history could cover the following areas:

a. Ethnic group, age, sex, size of family, and previous occupation (previous occupation might provide an indicator of previous medical conditions and/or familiarity with Western health care; e.g. if a refugee had had military duty, the interviewer might inquire about battle experience, wounds, etc.).

b. Migration history (location of refugee camp and length of stay).

c. Medical history which focuses on:

(1) surgery and hospitalization

(2) medication (including herbs and other folk-medicines)

(3) significant medical conditions (Use of descriptive rather than technical terms to elicit information in the interview may prove fruitful; e.g., describing malaria in terms of fevers, chills, mosquito bites. Technical terms for

some medical conditions either do not exist in the various refugee languages, or are not known by the refugees.)

d. Tuberculosis

e. Allergies (any reactions to food or drugs)

f. Gastrointestinal (problems with diarrhea)

g. Immunizations

h. History of smoking and drinking

i. Review of all available records

2. Physical Examination

a. Refugee medical conditions.

To facilitate the examination, the physician should be aware of medical conditions that are prevalent in the refugee population. These include: skin conditions (including scabies, lice, fungal infections, and impetigo); parasitic diseases (intestinal, liver, lung); malaria; tuberculosis; otitis media; conjunctivitis; anemias; congenital and rheumatic heart disease; thyroid goiter; dental disease.

Experience has shown that the prevalence of problems generally occurs across age groups and sexes, and therefore screening should be provided for all refugees.

b. Appropriate procedures.

Certain procedures in a routinely performed physical exam would be inappropriate with newly arriving refugees. For example, examination of

genitalia would be unacceptable to most Indochinese women, including those who have had children.

c. Examination content.

The physical examination could cover the following:

(1) Vital signs (general appearance, blood pressure, height, weight, pulse, respiration, temperature)

(2) Skin

(3) Lymph nodes

(4) Head, Eyes, Ears, Nose, Throat, Mouth, Neck

(5) Heart

(6) Lungs

(7) Abdomen

(8) Spine

(9) Extremities

(10) Neurological exam.

3. Laboratory Procedures

a. Cultural factors.

Physicians and clinical personnel need to be aware of the reluctance among some of the refugee ethnic groups to have laboratory tests performed. There is particular fear and resistance to the drawing of blood (venipuncture). Many refugee patients do not understand that the body reproduces blood, and they feel that the withdrawal of blood will endanger their lives and health. Consideration should be

given to performing only the most minimal procedures necessary (finger prick, for example).

b. Recommended procedures.

The following laboratory procedures are recommended as addressing the above cultural concerns, as well as being relatively cost-effective.

(1) Skin test -- 5 TU PPD for those 35 years and under, and for those over 35 with an abnormal X-ray and a doubtful or undocumented tuberculin status.

(2) P.A. chest X-ray -- for those 15 years and older, and if previous X-ray is more than 90 days old or is of poor quality.

(3) Parasites -- one stool specimen for ova and parasites.

(4) Urine-dip stick -- if positive, micro.

(5) Thick blood smear -- if indicated by fever, headache, enlargement of the liver or spleen, and if malaria is suspected.

(6) CBC (Clinical Blood Count).

(7) Hepatitis B antigen -- necessary for pregnancies only and therefore would be conducted under primary care (Testing for hepatitis B antigen in those refugees needing dental care is felt to be an individual community option reflecting particular local concerns.)

4. Needs Assessment for Referral to Supportive Health Services

Health assessment programs should include the capability for identification of other health needs of the refugees, and documented referral to appropriate services, including primary care clinics,

and secondary and tertiary care providers. These health needs include:

a. Family Planning -- The following considerations need to be addressed in assessing and referring the refugee:

(1) willingness to participate
(2) family size
(3) past and current pregnancy
(4) age and physical condition

b. Dental Care -- All refugees should be given an oral inspection. Medical personnel (physician, nurse practitioner, or a physician's assistant) could perform this inspection if appropriate dental personnel are not available.

c. Vision and Hearing -- All refugees should be screened by means of a brief history, Snellen chart, gross hearing observation, and audiometry if available.

d. Nutrition -- All refugees should be screened by means of a brief history, and examined for anemia, height and weight (norms may need to be developed for refugee populations), skin folds, gross malnutrition and vitamin deficiency. Age inaccuracies on refugee medical and biodata forms may have produced understated nutritional deficiencies (see MMWR, Oct. 3, vol. 29).

e. Mental Health -- Physicians and other clinical personnel need to be aware of, and sensitive to, the potential adjustment problems caused

by the stress of resettlement, family dissolution and disruption. Wherever possible, consultation should be arranged with trained bilingual/bicultural personnel, before a referral is made, both to ensure accuracy of the assessment and appropriateness of the referral.

C. Delivery Considerations

Planning and development of health assessment services can take place at more than one level. Overall direction is needed to facilitate the delivery of services. The two most common structures exist at the state level and local levels.

1. State Planning Structure

The state approach involves state-wide planning for health assessment services (not the actual delivery of these services). The Refugee Act of 1980 promotes the development of state-wide planning - a task many states are undertaking for the first time. A state-wide approach and structure can provide overall direction for:

a. meeting state and local service needs,
b. assessing the population shifts,
c. developing protocols for service delivery,
d. promoting coordination of efforts,
e. establishing one central office for information,
f. monitoring and directing funds,
g. providing technical assistance, and
h. maintaining close relationships with the central and regional federal refugee offices, and a working knowledge of their policies and procedures.

Possible agencies which could provide state direction for refugee services include:

- State Health Department
- State Refugee Resettlement Office
- State Department of Public Welfare
- Voluntary Agency statewide activities

2. Local Planning Structure

The local structure often combines both planning and delivery of health assessment services within the same agency or organization. One local agency/group can take the lead in bringing about the coordination and linkage of several local health care providers. The lead agency would identify local needs, and encourage the use of ongoing services and facilities. The lead agency could be a:

- local health department
- hospital
- private clinic
- local medical organization

3. Direct Service Providers

The number of refugees in a given geographic area as well as the projected refugee arrival rates, are major factors in determining the health assessment service approach that is most appropriate.

a. A large, highly-impacted urban area can consider various alternatives:

(1) Centralized health assessment service with pooled resources, including full-time, on-site interpreters at a city/county health department

(2) Permanent community clinic space, associated with defined neighborhoods and ethnic groups

(3) Hospital out-patient clinic

(4) Mobile teams of screening personnel using clinic space on a temporary basis

(5) Volunteer clinics run by voluntary agencies

(6) Private physician/clinic offices using mobile interpreters

(7) Early Periodic Screening Diagnosis and Treatment (EPSDT) clinics for children

(8) U. S. Public Health Service hospitals and clinics

(9) National Guard or Army reserve medical units

(10) Federally-assisted community health centers

(11) Others.

b. Smaller cities or contiguous counties with refugee families living in close proximity may be able to utilize some of the same services as identified above. However, their main sources of services could probably be drawn from local health departments, hospitals, physicians in private practice and volunteer clinics.

c. Small rural communities with scattered refugee families may be limited to relying heavily on physicians in private practice; or they may be able to coordinate with larger nearly communities for regional screening clinics on a scheduled basis, using hospitals, health departments, federally-supported rural health initiative clinics, or college clinics as sites. Regional arrangement often means that bilingual interpreters are more readily available.

CHART III: SERVICE PROVIDER OPTIONS FOR HEALTH ASSESSMENT

HIGHLY-IMPACTED URBAN AREA

- Centralized Health Assessment Services (for Pooling of Resources)
- De-Centralized Services (for Geographic Accessibility)
- Permanent Community Clinic Space
- Hospital Out-Patient Clinics
- Mobile Screening Teams
- Voluntary Agency Clinics
- Private Physician/Clinic Offices Using Mobile Interpreters
- EPSDT Clinics for Children
- U. S. Public Health Service Hospitals and Clinics
- National Guard or Army Reserve Medical Units
- Federally-assisted Community Health Centers

SMALLER CITIES/CONTIGUOUS COUNTIES

Some of the services listed above may be utilized. Primary options for services would probably be:

- Local Health Departments
- Private Practitioners
- Hospitals
- Voluntary Agency Clinics

Regional screening clinics on a scheduled basis may also be possible, using hospitals, health departments or college clinics as sites.

RURAL AREAS/SCATTERED POPULATIONS

Primary option would probably be private practitioners, although regional screening clinics may be possible through coordination with larger nearby communities. Federally-supported rural health initiative clinics may provide additional resources.

IV. ONGOING HEALTH CARE FOR REFUGEES

A. Background

The concept of ongoing care for refugees includes both the:

a. initial treatment of problems identified in health assessment and

b. the enrollment of refugees in prevention and maintenance programs.

There are several key issues for communities to consider in their planning and development of this last part of the refugee health care continuum. Chief among these issues are the availability, accessibility and acceptability of the ongoing care services.

The cautions raised above regarding the need for appropriate health assessment services for refugees are equally important for ongoing care. The need for understanding and sensitivity on the part of the American health care provider, and the importance of interpreters and bilingual/bicultural health workers and professionals, cannot be overemphasized strongly enough.

Ongoing health services for refugees are divided below into three categories:

1. Essential Services
2. Important Services
3. Desirable Services

These categories can be considered by communities in planning and developing appropriate ongoing services, according to community needs and available resources.

B. Service Activities

1. Essential Services

The services listed in this category are viewed as absolutely essential for any ongoing care program. They include:

a. Emergency care on a 24-hour basis (including emergency dental care).

b. Primary medical care, including the follow-up of communicable diseases like tuberculosis, venereal disease, etc., and the diagnosis and treatment of common problems. Primary care would also include the following types of care:

- Pediatric (including CDC protocols for immunizations, and well-baby programs)
- Adult
- Ob-gyn (Obstetrics-Gynecology), including pap smears and pre-natal care.

c. Interpreter services incorporating a bilingual/bicultural approach.

d. Transportation services.

e. Enrollment in some type of payment program (public or private).

f. Home services.

g. Information on WIC and Food Stamp programs.

h. Referral as necessary.

i. Follow-up for all services.

2. Important Services

The services listed in this category are viewed as important for ongoing care programs. They include:

a. Timely dental care.

b. Family planning, involving both partners and choice of method.

c. Mental health care.

d. Health education, including general orientation and instruction in hygiene, sanitation, first aid, and living skills, utilizing live presentations, as well as printed and audio-visual materials.

e. Nutrition information, including meal planning, food purchasing, use of food stamps, food equivalents, and diet-related diseases.

f. Standardized records for refugees to facilitate continuity of care (patient information records could take the form of a card for refugees to carry).

3. Desirable Services

The services listed in this category are viewed as desirable for ongoing care programs. They include:

a. Linkage of primary care with secondary and tertiary care.

b. Linkage of primary care with hospital care of refugee's choice.

c. Services to special groups needs (e.g., day care).

d. Periodic health assessment.

C. Delivery Considerations

Most communities want a comprehensive approach in providing health services to refugees; the reality is that services must often be improvised on short notice in response to crises, and little planning and coordination is possible.

Communities can use the suggested ideal service options and alternatives identified below as guidelines for adapting available resources to meet refugee health needs.

1. Coordinated Community Services

a. A unified system offering comprehensive health services with full-time bilingual/bicultural staff is the ideal.

b. Alternatives for all geographic areas could include:

- Involvement of voluntary agencies and other social services as supportive linkages to primary care programs.
- Developing a resource directory giving guidance to refugees on appropriate ways to select appropriate options from the array of health service options which exist in many communities.
- Orientation of refugees and providers on culturally sensitive health issues, and education for providers on appropriate referral patterns.

2. Specialized Programs for Refugees

a. Specially designed programs that are targeted only for refugee clients are ideal for many communities. An example of this is the recently funded WIC demonstration projects which have combined regular nutrition services with outreach, data collection, and development of culturally appropriate materials.

b. Alternatives could include special piggy back or add-on refugee service components to already existing programs. These programs could include the following elements:

- Centralized intake for refugees.
- Easily recognizable medical forms and referral slips alerting personnel to the refugee's special needs.
- Outreach and transportation.
- Interpreter services.

3. Personnel

a. Bilingual/bicultural health providers serving in a neighborhood health center or some other community based setting have been found to be most effective to some communities.

b. Alternative staffing patterns could include the following:

- Health department personnel (preferably with cross-cultural experience).
- Hospital outpatient clinic staff.

- WIC-certified physicians cooperating with school or hospital dieticians to provide nutrition education.
- Culturally sensitive individuals, such as former Peace Corps volunteers, to provide outreach.
- Refugee volunteers.
- Community volunteers, including health providers.
- Private providers.
- Any of the above, linked with bilingual interpreters.

4. Interpreter/Translation Services

   a. Full-time, trained, bilingual/bicultural staff is the ideal. This is most feasible in high density areas.

   b. Alternatives (and/or additional approaches) could include:

      - Part-time or on-call bilingual interpreters.
      - Hotline providing telephone links between bilingual health interpreters in high density areas and services in low density or rural areas.
      - Volunteers from the refugee community.
      - Audio-visual materials featuring specific instructions and information.
      - Explanatory phrase books and illustrations.

CHART IV:	COMPONENTS OF ONGOING CARE
ESSENTIAL SERVICES	• EMERGENCY (24-HOUR) MEDICAL CARE (including dental care) • PRIMARY MEDICAL CARE - Follow-up of Communicable Diseases - Pediatric: Immunizations - Adult - Ob-Gyn: Pre-natal • INTERPRETER SERVICES • TRANSPORTATION SERVICES • FINANCIAL PAYMENT PROGRAM • HOME SERVICES • WIC, FOOD STAMPS INFORMATION • FOLLOW-UP
IMPORTANT SERVICES	• DENTAL CARE • FAMILY PLANNING • MENTAL HEALTH • HEALTH EDUCATION • NUTRITION • STANDARDIZED PATIENT INFORMATION RECORD
DESIRABLE SERVICES	• LINKAGES WITH SECONDARY-TERTIARY CARE • LINKAGES WITH HOSPITAL CARE • SPECIAL-GROUP SERVICES (e.g., Day Care) • PERIODIC HEALTH ASSESSMENT

V. IMPORTANT SUPPORTIVE SERVICES

The options for service delivery as presented in the sections on Identification-Intake, Health Assessment, and Ongoing Care are dependent on two extremely important supportive services. The first, bilingual personnel, has been referenced throughout the document. This section secondly explores the various financial mechanisms that may be available to a health care program.

A. Bilingual/Bicultural Personnel

The importance of bilingual/bicultural personnel has been discussed above. Communities need to consider the number and types of bilingual personnel which could be utilized and their need for training. Interpretive services may be provided through the following kinds of personnel:

1. Translators - Their function is to translate simple, straightforward materials used in orientations and patient instructions, etc. Translators require little or no previous background in health.
2. Interpreter/health aides - Their function is to provide interpretation between patients and health care providers, do outreach and direct patient education and orientation, and bicultural training of staff. Persons may have had health training in their own country or may receive specialized health training here.
3. Bilingual/bicultural providers - Their function is to assist American health care providers or provide direct services. Persons may be in the process of becoming licensed here in America after being initially trained

in their own country. They may work in positions such as medical assistants while in the licensing process. Others may have already completed their examinations and training programs and are qualified to practice their professions.

Training programs for the interpreter/health aide should be part of the planning considerations. Options can include on-the-job training, seminars and workshops and formalized training programs. Subject matter needs to address:

- language and cultural differences
- medical terminology
- medical and health care philosophy
- local health service systems and structures
- sensitivity to and advocacy for refugee needs.

B. Financial Mechanisms

The ability of a community to plan and develop health services is directly related to the availability of financial resources. Limited resources may sometimes find community agencies in the dilemma of shrinking services for one population while trying to find additional resources for the steadily increasing number of refugees.

Listed below are the kinds of financial supports utilized by the health practitioners in developing their programs:

1. Refugee social service funds from the Office of Refugee Resettlement, Department of Health and Human Services. Formerly identified as IRAP dollars, these funds are now available under the regulations of the Refugee Act of 1980.

The funds are tied directly to Title XX categories and can provide funding for supportive and health-related activities. These funds usually are not used for hands-on care by physicians, nurses, laboratory technicians, etc. The categories under which services can be funded include:

- Outreach services.
- Social adjustment services, including information and referral, emergency services, health-related services, home management services.
- Translation and interpreter services, including training of these personnel.

2. Medical Assistance including both Title XIX and non-Title XIX. Presumptive eligibility is currently being considered and may provide additional assistance in getting refugees into health assessment programs without having to wait for the enrollment procedures to be completed.

3. Hill Burton funds available through hospitals for those patients who have limited ability to pay.

4. Special designated funding, usually one time demonstration money (for example, refugee WIC monies).

5. Foundation grants, usually available for seed money to get new programs or services started.

6. EPSDT (Early and Periodic Screening, Diagnosis and Treatment funds available for health assessment of children. Clients must be Title XIX-eligible. The program may reimburse for outreach and follow-up.

7. Urban and Rural Health Initiatives -- Comprehensive care providers are funded under Section 330 of the Public Health Service Act.

8. Public Health Service grants have been made available by application through the Center for Disease Control to assist states in meeting public health needs and in providing initial health assessments.

9. Sliding fee scales in public facilities, based on the client's ability to pay.

Appendix - A

The Practitioner Workshop Project
Health-Related Services Workshop

The Practitioner Workshop Project is a project of the Indochina Refugee Action Center, conducted under a grant from the Department of Health and Human Services, Office of Refugee Resettlement (HHS/ORR) (Grant #96-P-10003-3-01).

A series of seven workshops is being held. Each workshop deals with a different social service or services which can be provided Indochinese and other refugees through Department of Health and Human Services Title XX and/or Refugee Resettlement Program social services funding. The workshops are:

Orientation	- August 1980
Health-Related Services	- September 1980
Social Adjustment	- September 1980
Vocational Training and Skills Recertification	- October 1980
Employment Services	- October 1980
Outreach, Information and Referral	- November 1980
Refugee Resettlement Service Delivery Approaches	- December 1980

The goals and objectives of these intensive workshops are to:

- develop practical models and approaches to serve as examples of effective programs and as stimulants to new, quality project development in resettlement communities;
- develop models to stimulate acceptance and to serve as a guide for state human service administrators charged with making refugee social service funding decisions;

- facilitate communication between resettlement workers regarding approaches used in other locales;
- provide input from knowledgeable local resettlement practitioners into national program operations; and
- increase the very limited body of knowledge on effective resettlement practice in very pragmatic terms -- to move forward the state-of-the-art.

Each workshop is comprised of approximately ten service providers who are involved in delivering social services to Indochinese refugees. Each workshop is three days in length, and is directed by a lead consultant designated by project staff. The lead consultant has primary responsibility for drafting a workshop report. For each of the workshops, the report includes an introduction, with a definition of the service(s); necessary program considerations; a description of appropriate delivery settings; and various models of approaches for delivering the service(s). The report is reviewed by project staff, workshop participants and by HHS/ORR, and then distributed by IRAC to major refugee resettlement practitioners.

The Health-Related Services Workshop was held in Somerville, Massachusetts, September 11-13, 1980. The lead consultant was Sandra DuVander, who is Health Coordinator for the Minnesota Office of Refugee Resettlement. The workshop was attended by fifteen participants, all of whom are closely involved in the provision of health services to refugees. An observer from the Center for Disease Control was also present. The names of the participants are attached. (See Appendix C for further information on the programs represented.)

Implementation Phase

This second six-month phase of the project will implement the practical models of service delivery developed in the workshops. Short-term, on-site assistance will be available to local resettlement practitioners who express a need for assistance in the program development areas covered in the workshops. Practitioners involved in the workshop phase will be linked with communities requesting implementation support.

The objectives of this implementation phase are to:

1. stimulate the development of effective refugee services in areas where services are either inadequate or non-existent;

2. encourage coordination among service programs, particularly in high-impact areas; and

3. assist specific groups (e.g., MAA's, voluntary agencies and other local service providers) in enhancing their capacity to provide service to refugees.

The implementation phase of the project will be directed by a coordinator. The coordinator will assist specific agencies and/or communities who indicate a need of program development by matching them with experienced local resettlement practitioners identified through the workshop process. These practitioners will provide on-site technical assistance in a number of communities around the country. Services provided on-site may include the following:

a. identification of the delivery model(s) appropriate to the agency/community and its specific needs

b. development of service delivery plans, including specific modifications and implementation concerns

c. follow-up assessment and evaluation.

Appendix - B

PRACTITIONER WORKSHOP PROJECT

HEALTH-RELATED SERVICES WORKSHOP PARTICIPANTS

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Appendix C is divided into two parts. The first part contains brief summaries of programs represented by participants in the workshops. The second part is an outline which matches the various programs represented with the topical categories into which the document is divided. Thus, if one wishes, for example, to learn more about health assessment programs, one can check the outline to see if there are materials and expertise developed by programs represented in the workshop.

FRANCIS CHANG
HENRY C. YANG, M.D.
South Cove Community Health Center
Boston, Massachusetts

For many years a community health center primarily serving Boston Chinese-Americans, the South Cove Community Health Center provides comprehensive health services to Indochinese refugees, with a full complement of health and mental health services. These include internal medicine; pediatrics; ob/gyn; dentistry; eye care; family planning; nutrition; health education; school health; adolescent, adult, and child mental health, mental retardation, and community outreach.

KHAMCHANH CHANTARANGSY
International Institute of Rhode Island
Providence, Rhode Island

Refugees sponsored by the International Institute of Rhode Island use the Providence Health Centers, which have four special Indochinese clinics funded by Federal monies through the Rhode Island Department of Health. One Cambodian female case aide and one Hmong case aide from the International Institute serve regularly at the Centers, in the Pediatric, Pre-natal, and Gynecological clinics. The International Institute and the Providence Health Centers cooperate in planning health classes for the refugees.

Recently, the Institute has provided financial administration for a community project aimed at providing emergency interpreting services during weekends and after office hours, through use of a 24-hour multilingual hotline.

SANDRA DUVANDER
State Refugee Office
Health Coordination Program
St. Paul, Minnesota

Minnesota has a state coordinated, locally administered refugee health program involving close cooperation with both the public and private sectors. The urban areas utilize linked public health department clinics and county hospital out-patient clinics offering screening, primary care and outreach to refugees. The rural areas utilize private physicians with support from public health services and nursing services for outreach and data collection.

All programs are supported by specially trained refugee health interpreters, state-wide assessment protocols, refugee packet medical cards, a state-wide hotline for health providers, an on-call interpreter service for after hours and on weekends, and centrally coordinated educational materials.

A state health advisory committee composed of health care providers in both the public and private sector, provides direction for the program.

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Center for Disease Control
Atlanta, Georgia

The major responsibilities of the CDC Tuberculosis Control Division related to the health care of Indochinese refugees are to: (1) provide technical consultation and assistance to state and local health departments regarding the management of individuals in the refugee population who have tuberculosis or may have been exposed to tuberculosis; (2) collect and analyze data regarding tuberculosis infection and disease rates among Indochinese refugees, and disseminate the results of the data to state and local health departments for their use in planning tuberculosis control activities; (3) provide advice to the Quarantine Division of CDC and the Refugee Health Project Grant program concerning the policies and procedures for the managment of tuberculosis. Other CDC activities specifically related to refugees, both domestically and overseas, are described in Appendix D.

ALVIN GRANT
Primary Care Program
Illinois State Department
of Public Health
Springfield, Illinois

The Illinois State Department of Public Health has taken the following specific measures to meet the health needs of refugees:

1. Established state-wide and local registries which will facilitate a tracking system for the settlement and resettlement of refugees and the scheduling and follow-through of appointments; a base for morbidity data retrieval; and a clearinghouse for information regarding the availability of medical services.

2. Identifies willing providers to assure that thorough medical examinations are available.

3. Expanded the Illinois Department of Public Health and the U. S. Public Health Service Clinic Laboratory capabilities to accomodate the submission of extra specimens.

4. Made provision for translation services to providers.

5. Established referral linkages with local sponsoring voluntary agencies.

6. Provides treatment information for tropical medical conditions.

7. Provides state and local coordination so continuity of services can be achieved without duplication.

BYRON HASLAM
Epidemiology Program
Utah State Department of
Health
Salt Lake City, Utah

During the period of October 1, 1979 through September 30, 1980, the Utah State Department of Health contracted with local health departments to provide basic screening and treatment services and follow-up, including completion of immunizations, monitoring of medications, health education and counseling, and referral to a source of ongoing care.

During this fiscal year, the main emphasis of the state's refugee health policy will be on tuberculosis control, but all medical problems will be evaluated and/or referred for follow-up and treatment.

GIAO NGOC HOANG, M.D.
Burgdorf/University of Connecticut
Indochinese Clinic
East Hartford, Connecticut

The Burgdorf/University of Connecticut Indochinese Clinic provides health assessment services for both newly-arrived refugees as well as refugees already resettled in the area who have not found a source of health care. The clinic provides comprehensive care including both adult and pediatric clinics, treatment, follow-up, referral, and assistance to clients in enrolling in a long-term health maintenance program. The Burgdorf/University of Connecticut Indochinese Clinic maintains close cooperation with sponsoring voluntary agencies, and other health-care delivery organizations.

Sr. BRENDA LEGE, RN
Indochinese Social Services
Associated Catholic Charities
New Orleans, Louisiana

The Health-Related Services Staff of the Indochinese Social Service Program provides comprehensive health counseling and referral on a weekly basis in community settings, local health facilities, and on an individual basis by appointment. Interpreter services are provided at the local public hospital on a 24-hour basis and to private health facilities as requested. Health education is provided on an individual or group basis, through home visits, and via the phone upon request. New arrivals are instructed regarding health facilities offering free screening and the means for follow-up care.

CARLOTA DE LERMA, M.D.
Indochinese Refugee Division
Pinellas County Health Department
St. Petersburg, Florida

Since early 1979, the Pinellas County Health Department has provided medical services to approximately one thousand Indochinese refugees through three clinics: 1) the General Medicine Clinic 2) the TB Clinic, and 3) the Immunization Clinic. Refugees are provided with basic screening and treatment services and follow-up. Referrals are made for maternal and child health care, WIC supplemental foods program, family planning, dental care, and mental health services.

On October 1, 1980, the Pinellas County Health Department, Indochinese Refugee Program received a grant from CDC's Bureau of State Services. The program has hired three interpreters and will shortly rent space and hire medical and para-medical staff. With this extra staff, the program will be able to do physical examinations on every refugee (prior to this, physical examinations were given to refugees under 21 years of age), follow-up on delinquent appointments, and enhance health education and nutritional counseling.

JEFFREY NEWMAN, M.D., M.P.H.
Public Health Service Hospital,
San Francisco
Indochinese Health Intervention
Program (IHIP)
San Francisco, California

The U. S. Public Health Service Hospital in San Francisco (PHSHSF) has entered into a contractual agreement with the Indochinese Health Intervention Program (IHIP) of Catholic Charities of San Francisco, Inc., to establish an integrated program of screening and follow-up of diseases (primarily acute and infectious) among Indochinese refugees arriving in the San Francisco area. PHSHSF provides basic screening and treatment services and referral to an appropriate source of continuing health care including mental and dental care. The Indochinese Health Intervention Program provides the following services: outreach; transportation; on-site health workers and translators (multilingual/multicultural); translation of health education materials; recruitment of, and referral to, health care providers and facilities; appointment scheduling; follow-up coordination with sponsoring voluntary agencies; and assistance in record keeping and statistics.

JOHN RIESS
Indochinese Refugee Screening Project
Seattle/King County Health Department
Seattle, Washington

The Indochinese Refugee Screening Project is a decentralized, multilingual mobile health team offering initial screening for communicable diseases and medical/dental problems including referral to appropriate sources of continuing care. The team provides screening, primarily during evening hours, in five geographically-dispersed health clinics, chosen because they are logical choices for ongoing care. The project 'piggybacks' onto a successful, neighborhood-based, primary care system which has the capacity to offer comprehensive health services and which has established links with other human service agencies.

AMY TONG, M.Sc.
Nutrition Consultant
Washington, D.C.

Amy Tong organizes and addresses workshops and training sessions in nutrition and diet for Southeast Asia refugees, including special emphasis on Southeast Asian food habits and preferences, as well as ways to make American foods more acceptable and palatable to refugees.

Presentations are based on the principles of good nutrition, and the role of good nutrition in the overall health care program and the prevention of certain diseases. Specific health and food beliefs and prejudices are described since they must be reckoned with in planning health education programs for refugees.

The outline below identifies workshop participants' programs with specific reference to refugee health issues and services as discussed in the various sections of this document. Communities may wish to contact the appropriate program for additional information and materials.

I. Introduction

A. Prevalence of Disease
1) Burgdorf/University of Connecticut Indochinese Clinic
2) Utah State Department of Health
3) Seattle/King County Health Department

II. Identification and Intake

A. Monitoring and Data Analysis - Seattle/King County Health Department (Computer System)

B. Outreach
1) Indochinese Health Intervention Program (IHIP), San Francisco
2) Indochinese Social Services, Associates Catholic Charities of New Orleans

C. Orientation - Indochinese Social Services, Associated Catholic Charities of New Orleans

III. Health Assessment

A. Screening Protocol
1) Illinois State Department of Health
2) Minnesota Office of Refugee Resettlement

B. State Planning Models
1) Illinois State Department of Public Health
2) Utah State Department of Health
3) Minnesota Office of Refugee Resettlement

C. Local Planning Models
1) Seattle/King County Health Department

D. Direct Services
   1) South Cove Community Health Center
   2) Public Health Service Hospital, San Francisco
   3) Pinellas County Health Department
   4) Indochinese Refugee Screening Project, Seattle/King County Health Department
   5) Burgdorf/University of Connecticut Indochinese Clinic
   6) Indochinese Social Services, Associated Catholic Charities of New Orleans

IV. Ongoing Care

A. Dental Care - Minnesota Office of Refugee Resettlement

B. Mental Health - South Cove Community Health Center

C. Standardized Patient Information Card - Minnesota Office of Refugee Resettlement

D. Community Coordinated Services - South Cove Community Health Center
   1) Supportive Linkages - Indochinese Social Services, Associated Catholic Charities of New Orleans
   2) Health Education Materials - Minnesota Health Education Resource Center

E. Specialized Programs for Refugees - Minneapolis Health Department, Minnesota
   1) 'Piggy-back' programs - Seattle/King County Health Department

F. Manpower
   1) Bilingual/Bicultural Health Workers - South Cove Community Health Center
   2) Health Aide/Interpreters
      - Minnesota Office of Refugee Resettlement
      - Indochinese Refugee Screening Project, Seattle/King County Health Department
      - Indochinese Health Intervention Program (IHIP), San Francisco

V. Supportive Services

A. Training of Health Aide/Interpreters - Minnesota Office of Refugee Resettlement.

B. Financial Mechanisms
   1) Title XX - Indochinese Social Services, Associated Catholic Charities of New Orleans
   2) Public Health Service Monies
      - Minnesota State Department of Health
      - Illinois State Department of Health
      - Public Health Service Hospital, San Francisco

3) Early Periodic Screening Diagnosis and Treatment - Minnesota Office of Refugee Resettlement
4) Medical Assistance - Non-Title XIX
   - Seattle/King County Health Department
   - Utah State Department of Health
5) Foundation Grants - Minnesota Office of Refugee Resettlement.

/Appendix - D/

Center for Disease Control

Contact Person

Joseph Giordano
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Quarantine Division
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The Program

The Center for Disease Control is reponsible for a range of activities relating to the immigration of refugees into the United States. These activities include the following:*

Overseas Screening for Excludable Health Conditions

Refugees must be screened overseas for health conditions which, as a matter of immigration law, may prevent them from obtaining a visa to enter the United States. CDC, in support of the Immigration and Naturalization Service (INS), is responsible for overseeing the procedures for screening. The actual screening is performed under a Department of State contract with the Intergovernmental Committee for European Migration (ICEM).

Overseas Immunization

CDC has participated in the development of an overseas immunization program for Indochinese refugees immigrating into this country. Immunizations are also carried out in cooperation with the Department of State and ICEM.

* U.S. Dept. of Health and Human Services, U.S. Dept. of State. Refugee Resettlement Resource Book (Washington, D.C.: Indochina Refugee Action Center, October 1980) pp. 123-125.

Quarantine Service

CDC has full responsibility for Quarantine Service at U.S. ports of entry. In response to the influx of Indochinese refugees into this country, CDC has:

- Hired an additional 15 quarantine inspectors and assigned them to quarantine stations which serve as primary ports of entry for Indochinese refugees; and
- Revised procedures for quarantine officers to stipulate that telephone notification to public health departments be made immediately -- followed by written notification within 24 hours -- for all refugees who enter with active (but noninfectious) tuberculosis. Written notification is also made for individuals who enter with inactive tuberculosis. A tracking system for tuberculosis referrals has also been established and includes telephone and written follow-up from CDC headquarters to health departments during the 90-day period following entry into the United States.

Project Grants - Health Programs for Refugees

CDC administers a grant program to help states and communities address refugee problems of public health significance, provide general medical screening to refugees, and identify other medical problems, particularly those which might affect the achievement of economic self-sufficiency. A total of $4.8 million is available for this purpose in FY '80. Funds will be allocated to the regional health administrators for award.

National Disease Surveillance and Control

CDC conducts national disease surveillance to develop strategies to control tuberculosis, venereal disease, parasitic disease and immunizable childhood diseases (measles, mumps, rubella, polio, diphtheria, pertussis, and tetanus). Through grants and technical

assistance to state and local health departments, CDC supports a variety of research, immunization, and other disease control programs.

Relevant Publications

CDC periodically publishes statistical results of sample health assessments of Indochinese refugees in its weekly MMWR (Morbidity and Mortality Weekly Report). The August 24, 1979 issue (Vol. 28, No. 33) made treatment recommendations concerning significant infectious disease problems among refugees. The October 5, 1979 and November 2, 1979 issues (Vol. 28, Nos. 39 and 43), respectively, provided information regarding hepatitis and diphtheria. Other relevant issues include Vol. 28, Nos. 43, 46 and 48; and Vol. 29, Nos. 1, 4, 19, 20, 29, 34 and 37.

Refugee Act of 1980: References to Health Services

The Refugee Act of 1980 (P.L. 96-212) establishes the following responsibilities and provisions for the delivery of health services for refugees.

First of all, in submitting a state plan for the delivery of domestic resettlement services, the state must include provisions

> "for the identification of refugees who at the time of resettlement in the State are determined to have medical conditions requiring, or medical histories indicating a need for, treatment or observation and such monitoring of such treatment or observation as may be necessary."

The Secretary of the Department of Health and Human Services has the following responsibilities in the identification and monitoring of refugee health needs:

> "The Secretary, in consultation with the Coordinator, shall --
> (A) assure that an adequate number of trained staff are available at the location at which the refugees enter the United States to assure that all necessary medical records are available and in proper order;
>
> (B) provide for the identification of refugees who have been determined to have medical conditions affecting the public health and requiring treatment;
>
> (C) assure that State or local health officials at the resettlement destination within the United States of each refugee are promptly notified of the refugee's arrival and provided with all applicable medical records; and
>
> (D) provide for such monitoring of refugees identified under subparagraph (B) as will insure that they receive appropriate and timely treatment.
>
> The Secretary shall develop and implement methods for monitoring and assessing the quality of medical screening and related health services provided to refugees awaiting resettlement in the United States."

In addition the Director of the Office of Refugee Resettlement, HHS, is authorized to:

> "...make grants to, and enter into contracts with, public or private nonprofit agencies for projects specifically designed...to provide, where specific needs have been shown and recognized by the Director, health (including mental health) services."

The Director of the Office of Refugee Resettlement is also authorized to:

> "provide assistance, reimbursement to States, and grants to, and contracts with, public or private nonprofit agencies for up to 100 per centum of the cash assistance and medical assistance provided to any refugee during the thrity-six month period beginning with the first month in which such refugee has entered the United States and for the identifiable and reasonable administrative costs of providing this assistance."

Further:

> "The Director is authorized to allow for the provision of medical assistance under paragraph (1) to any refugee, during the one-year period of entry, who does not qualify for assistance under a State plan approved under title XIX of the Social Security Act on account of any resources or income requirement of such plan, but only if the Director determines that -
>
> (A) this will (i) encourage economic self-sufficiency, or (ii) avoid a significant burden on State and local governments; and
>
> (B) the refugee meets such alternative financial resources and income requirements as the Director shall establish."

No determination has been made as yet regarding this "presumptive eligibility" for medical assistance.